DOCUMENT RESUME

ED 220 118 JC 820 307

AUTHOR Clavner, Jerry B.; Sumodi, Veronica R.
TITLE Anthropology for Contemporary Nurses: A Paper for Consideration.
PUB DATE 17 Apr 82
NOTE 27p.; Paper presented to the Central States Anthropological Association (Lexington, KY, April 10, 1982) and to the American Culture Association (Louisville, KY, April 17, 1982).

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS Anthropology; *Cross Cultural Training; Cultural Awareness; Cultural Differences; Education Work Relationship; *Interdisciplinary Approach; *Interpersonal Competence; *Learning Activities; Nurses; *Nursing Education; Postsecondary Education; Sociocultural Patterns

ABSTRACT

The integration of culturally relevant concepts into nursing education is essential for the effective delivery of health care in a modern, multi-ethnic, multi-racial, mobile society. Several key concepts from anthropology and specific areas of individual interpersonal behavior have particular relevance to nursing education. It is important, for instance, that nurses understand the culture of the hospital, clinic, or other health service setting in which they work. They need to recognize structures of power and authority and be able to function with skill and flexibility within complex hierarchical organizations. Nursing students themselves become involved in the processes of acculturation and resocialization once they finish their training, and an anthropological perspective may ease the transition. The effectiveness of the nurse as a practitioner is increased by awareness and understanding of cross-cultural differences in, for example, religion, territoriality, and attitudes toward family. Even within the same society, cultural components of wellness and illness, such as tolerance for pain, may vary greatly. Additionally, nurses must have an awareness of language differences and communication skills and the importance of understanding patients and being understood by them. Comprehension of these culturally relevant concepts and issues can be facilitated through the integration of learning experiences with obvious applicability into existing courses. Samples of such learning experiences are appended, including definitions of concepts, suggested readings, learning activities and discussion topics. (KL)

**********
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
**********

ED220118

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
Jerry B. Clavner

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

U.S. DEPARTMENT OF EDUCATION
NATIONAL INSTITUTE OF EDUCATION
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
☒ This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.
• Points of view or opinions stated in this document do not necessarily represent official NIE position or policy.

# ANTHROPOLOGY FOR CONTEMPORARY NURSES*

## A PAPER FOR CONSIDERATION

CENTRAL STATES ANTHROPOLOGICAL ASSOCIATION
LEXINGTON, KENTUCKY
10 APRIL 1982

AMERICAN CULTURE ASSOCIATION
LOUISVILLE, KENTUCKY
17 APRIL 1982

* 'digging in' to nursing process

Jerry B. Clavner, Ph.D.
Veronica R. Sumodi, R.N.

JC 820 307

INTRODUCTION

Both of the fields of nursing and cultural anthropology are dynamic processes and have in common a person-oriented raison d'etre. They are both currently analyzing their practices, establishing new goals, involving themselves in new research and experimenting with new approaches relative to their fields.

As authors of the following work, we are proud to be involved in exploring one aspect of contributing to our respective and each other's field. We begin with an overview of the history of our professions and their interrelatedness. We then use examples of actual issues, in terms of both structure and process, to offer suggestions for education of nursing students to improve their effectiveness in their chosen career. At the same time, we are developing a practical application approach to general education, using anthropology as the example.

This paper is submitted as an attempt to encourage a sympathetic symbiosis between these two fields, between technical education and general education, and to provide the student with experience on a practical and hopefully realistic level.

We have learned and have begun to really understand that contemporary culture in the United States is not monolithic. Both the "new" anthropologists and the cultural historians have helped us come to this realization. The anthropologist, for his part, possibly, out of a lack of other objects of attention, decreased funding, the ugly American-self-effacement syndrome, and the sheer fact of change, has turned his attention to our society. It is important to note that until recently our culture was described in a manner that if brought back from the "bush" would have been viewed with more than a little scepticism. Rarely was U.S. culture examined with the same rigor or perspective as had (to be done) with more exotic groups. There was also a tendency to report

on the deviant, different, and abnormal in contrast to what has been the general/ holistic perspective in the study of other cultures.

It might even be said that it wasn't until sociology began using anthropological methodologies and presented its data with an ethnographic flavor that anthropology began to see its own potential and, one might say, responsibility, here at home. While anthropology is still a long way from perfecting its approach to our culture with its complex class, status, and power structures and while the data is still quite limited, recent strides have been made that may make anthropology the applied social science of the 1980s.

The cultural historians -- much it would appear, as a result of the shock of the Holocaust, the "bomb," Vietnam, Watergate, and the "disappearance of traditional culture" -- have begun to look for more inclusive paradigms, frameworks, and models. In addition they have begun using anthropological methods in their attempt to preserve more of the past. The lack of continuity in the historical process since the end of World War II, the "end of ideology," and the work of the conflict theorists have brought the anthropologist and the cultural historian very close together. The anthropologist for his part has seen the need for the inclusion of a more sophisticated historical perspective as part of his ethnography and ethnology.

This advancement of knowledge and the interdisciplinary fertilization is a positive sign in and of itself, but even more important, at least for some of us, is the issue of application.

> SCIENCE BY ITSELF IS KNOWLEDGE, SCIENCE APPLIED IS TECHNOLOGY;
> SOCIAL SCIENCE BY ITSELF IS KNOWLEDGE, SOCIAL SCIENCE APPLIED
> IS POLICIES AND PROGRAMS.

This paper addresses one aspect of the application of social science knowledge available in anthropology for the delivery of health services.

Policies and programs based on anthropology may have a better chance of being accepted and therefore facilitating the enhancement of life chances and life choices than policies and programs heretofore based on other social sciences. Examples of governmental, institutional, and organizational applications of psychology and sociology are particularly embarrassing in their lack of sensitivity, wastefulness, and deleterious long range effects. While some of our anthropology colleagues are "gun-shy" after the debacles of AID programs and Vietnam, we must simply acknowledge our mistakes and our limitations and go forward with a more respectful perspective in the future.

To look at the possibilities of the application of anthropology to a specific area we have selected nursing. The changes in nursing that have occurred are a result of significant advances in technology, an increased concern for professionalism, pressure from accreditating agencies, expansion of needs in the greater community, the (sometimes pseudo) understanding of medicine by people, the issue of accountability, and the increased complexity of society as a whole. These changes have affected the practice of nursing and nursing education has responded well considering all the pressures. A psychosocial approach has brought nursing out of the doctrine of illness treatment of component organic systems to a perspective of holistic health care with a clear emphasis on maintaining or re-establishing wellness.

Much of this new attitude can be accounted for by the absorption of anthropological generalizations taken into the fields of sociology and psychology and their subsequent adoption by nursing education. It is our contention that nursing education can be advanced even further if more anthropology is integrated directly into nursing education. It is felt that

the integration of culturally relevant concepts into the learning process of nurses is essential for the effective delivery of health care in a modern, multi-ethnic, multi-racial, mobile society.

It is not the purpose of this paper/work to simply add to the curriculum. We realize that most technical programs are not going to add more social science courses and may very easily reduce the general education requirements under pressure of funding patterns and the technological information explosion. Thus, it was tempting to simply take the terms from the indexes and glossaries of the introductory anthropology textbooks that seemed most relevant and list them with definitions. We have learned, though, that material that is not obviously useful is quickly forgotten. Nursing instructors are busy enough with their current responsibilities to try and figure out what they needed and how to use it. It seemed more functional to take a few terms and develop learning experiences that could easily be "plugged into" existing courses. These activities/experiences/exercises presented can serve as models for teachers in other technical fields that are currently overwhelmed with changes in their own fields and do not have the leisure to explore the possible contributions of the social sciences and the humanities to their students' education. The activities should also encourage the social science instructors to search out technical career instructors to get assistance in making their courses more relevant.

In order to provide more than an intellectual exercise, several steps were taken in the construction of this paper.

1. A listing of core concepts in anthropology from introductory texts was made.
2. Validation of concepts from applied anthropology resources was conducted.

3. A concept/content analysis of texts used in nursing foundations and nursing process courses for inclusion of anthropological concepts was done.

4. Where major concepts from anthropology were not discussed, a list was made.

5. From this list, exercises that could easily be accomplished were developed.

These exercises (see Appendix) include objectives, suggested readings, the activity, and write-up or discussion topics. The concepts picked were those that instructors and students in nursing perceived as most important.*

BACKGROUND

The relationship between anthropology and nursing education is quite old if we are willing to recognize the antecedents of this relationship in the natural sciences and social philosophy of the ancient and medeival world. We must also acknowledge work done in the Arab world, India, the "Far East," and other non-Western societies. There is evidence in early writings of "crude" forensics, prescriptive biology, immunology and the nature of diseases ofsome cultural or racial data. Differences in "constitutions" were often studied by those interested in health care, including mental health. The work of the phrenologists cannot be ignored, nor can that of the eugenics engineers, like John Humphrey Noyes, with his perfectionist doctrine of stiripculture at Oneida. Finally, the Third Reich's attempts to develop a master race must be mentioned.

The authors of this paper, an anthropology instructor and a registered nurse, have just begun their study of the health services and the social sciences and the following describes one aspect of this relationship.

*Exercises for particular concepts are marked.

THE NURSING ENVIRONMENT

We must look at the realities of the world in which we work in the health services. We are involved in an environment, both natural and man made that is different than anything that has come before. This is not a facile statement. While each and every generation sees the changes that occur in its time and space as radical and revolutionary, the changes since the end of World War I in all aspects of our institutions are tremendous. The advancements in technology, particularly in the health services, and the advancements in communications have ramifications and impacts in the configurations of everything we do. Each of us in our professional and personal life must understand and relate pro-actively to these changes. We must not simply react and use technology as the whipping boy of the problems of the contemporary world .

We are not contending that our health services personnel are not adequately trained in this new technology. The opposite is true, the training today is the best ever. Our over-all concern relates to the ability to relate to this technology. We need knowledges and skills to cope with this technology in our chosen occupation and the rest of our life outside of work. Please note, we are also not dealing with the large area of medical anthropology. While the cross-cultural study of disease and illness is interesting and should be of concern to all health professionals, we here are looking at some specific areas of individual interpersonal behavior within its cultural context in the nursing setting.

Context

The culture of the hospital, clinic, or other health service setting must be understood in order to deal with the topic. To assume that the ethnography of the relationship between the practitioner and the patient/client is the only variable is erroneous. For example, formally inside and generally outside the health services, there is a tendency to accentuate status differences among

the various occupations, services, and activities. A nurse's aide is different than a practical nurse is different than a registered nurse is different than a nurse clinician, even though in reality, their actions, interactions and sentiments are often the same. How all these roles relate to each others and to others can lead to cooperation or conflict, responsible or shirking behavior, and hierarchical or democratic arrangements of work.

Historically, health service workers have been viewed as selfless public servants, who are, except for physicians and certain other specialists, paid well below what they feel they should be paid. This situation can cause individuals to develop behavior which under different circumstances would have been dedicated and committed. Even where this is not a problem, the complexity of the work situation, including the extensive use of "policies," procedures, and rules, is viewed by personnel "in the trenches" as restricting their professional discretion. Administrators and supervisors are often viewed as insensitive, nonunderstanding, and too far removed from the day to day activities. Forced change or rigid maintenance of the status quo are viewed with hostility and sabatoging behavior.

Power and Authority*

Authority is an issue even under ideal conditions. Except for the private office and a few other circumstances, each category of functionary (e.g., nurse, physician, therapist, aide) has its own director/manager/head to which /sic/ the individual stands in a formal subordinate relationship. Individuals in the work situation, though, are responsible to other individuals (e.g., the surgical nurse is responsible to the surgeon). One must also make the distinction between these two forms of institutionalization of power on one hand and the ability to "command respect." In a structured organization within a structured society, the arrangements of relationships is based upon established statuses with relative amounts of power, privilege, and prestige. The "chain of command" which is

associated with bureaucracy is necessary within a complex organization. The health care practitioner must be able to operate within the formal structure of the setting; the alternative is chaos. But, efficient and effective care can best be delivered in a different manner. Thus, the nurse must learn both the formal and informal processes of the setting and be able to make the distinction between circumventing the authority system because of need and simple disrespect.

VALUES AND PROCESS

One of the issues that is presumed throughout this paper is that the nursing student is in the process of <u>becoming</u> a member of a new society (for him or her), with its particular culture and thus needs to learn how to behave. The student's teachers, clinical supervisors, and peers will provide direct instruction and support, but the processes of acculturation and resocialization are generally learned only once a initiate is a full-fledged member. This form of culture shock is often needlessly traumatic.

One of the purposes of this paper is to provide some mechanisms to reduce the adjustment problems, prevent conflict, and encourage a more positive attitude toward the real work world. Burnout, cynicism, fatalism, and callousness must be avoided. There is also the hope that the nurse who learns anthropological perspectives will remain a little aloof from the "natives," and be more objective and realistic in working with patients/clients and personnel from diverse cultural backgrounds. This student should also be able to distinquish between functional and dysfunctional change.

As we reviewed nursing curricula, we found that the integration of process issues and content was given some discussion time, but less clinical association. There is some acknowledgement of cultural issues, but relatively little time is devoted to real life situations. The more theory oriented the program, the

less clinical experience is seen in the areas we are addressing.

In nursing texts, including several books in Hebrew and texts written specifically for ethnic awareness, there appeared to be a concern for certain culturally relative issues. Awareness of family, diet, folklore, including folk medicine differences was dominant, but issues of intergroup and interpersonal relationships within the health care setting was given minimal attention. Racial-color issues are discussed, but few solutions are offered except in the area of diagnostics. There is an overriding impression that once cultural phenomena are mentioned, educational responsibility has been properly discharged. In only one supplementary text was there any attempt to indicate to the nursing student that she/he has a role to play. The holistic concept of nursing requires more than this psychological approach to issues of culture.

It is necessary to make some statements about the limitations of these discussions. One must be careful to avoid a form of cultural reductionism by attributing cultural causes to complex phenomena. Culture is differentially learned, understood, and internalized by each member of a particular society or sub-group. That an individual may come or appear to come from a specific aggregate does not mean that one can "blame" his/her behavior on culture. All blacks, all chicanos, all Puerto Ricans, all Vietnamese are not alike, nor is their adherence to our perception of their traditions. For example, a portion of Vietnamese are Catholic, so that their behavior may be different than a Vietnamese with a Buddhist tradition. Their views on the role a family should play with, say, impending death would be different. Further, Vietnamese from the urban centers of the south may have a different percpetion of health care by "foreigners," than Vietnamese from the rural north.

Here a special note about religion must be included. To note on an admission card that a person is of a particular religion does not respond to the complexity of the issue. In what would appear to be extreme cases, as with Orthodox Jews, Jehovah's Witnesses, Christian Scientists, etc., the nurse is assumed to be cognizant of potential problem areas. But we must also be aware of behavior that may appear to be idiosyncratic, while it is related to the practices and beliefs of a religion. Sorcery, personal spirit communication, impersonal forces, and magic may have significance. So too are jewelry, icons, amulets, even certain colors, flowers, or words.*

Religion is a good example of so-called cultural residuals. Cultural residuals may be attitudes or behaviors that have been carried over from past generations and are internalized, often with a high degree of denial, into the individual's repertoire. An individual who constantly uses his hands in communication may have no other sense of his ethnicity, but might display resistance to intravenous procedures if his arms were restained. Or, an individual from a culture that has a different sense of territoriality/proxemics may become uncooperative if the attending professional is too close physically (especially without explaining the need for closeness), or vice versa. Some cultures are vey "touchy" and may misinterpret "professional distance" as lack of concern.

Even in the area of nursing care of the aged, little is said about cross-cultural issues. "Reversion to traditional coping mechanisms" just doesn't explain the diversity of behavior. A significant segment of the older population of this country has never been fully integrated into the dominant culture.* The immigration since World War II, consisting mostly of older people and the residential mobility of the older population as a whole calls for a higher level of sensitivity and sympathetic action on the part of health care professionals.

Related is the issue of language and language competence. We have usually assumed that unless we had documentation of mental incapacity, brain damage, or foreign birth, we could communicate effectively and in general understand our patients. But, language competence is not the same for all segments of any specific population, let alone among individuals who have been reared in different locations. Nor can we assume that we as professionals are always making ourselves understood. Because our effectiveness is based on our ability to communicate effectively, we must work on our ability to do this.*

Finally, a concept which is beginning to receive attention in anthropology, the cultural components of wellness and illness. It is not safe to assume that our conceptions of wellness and illness are universally shared. It is as variable as concerns over toilet training, weaning, death and dying and cleanliness. Even within our own society, our lack of tolerance for pain is different among different segments of the population. We expect that our patients will tell us (when we ask only) whether they are experiencing pain. Further, we expect them to locate it and describe its nature. Tolerance for pain, non-admission of discomfort, and resistance to treatment must be understood within a cultural as well as a psycho-physiological context. The symbolism of submission, invasion of privacy, the necessity of maintaining body integrity must be related to conscious and unconscious resistance to treatment and care.

CONCLUSIONS

It has been our purpose to suggest some of the content areas of anthropology that relate to nursing as a culturally relative career. Nursing was chosen because as a changing field, it has shown understanding of its role in a modern, complex society. It has demonstrated a willingness to utilize new resources, both human and technological. Nursing has maintained its

vitality through adoption of a holistic model. Anthropology was chosen because it is the only discipline broad enough to deal with a dynamic situation.

Additional culture concepts need to be utilized in the study of health services. Of particular interest is the study of the language of health services, age grading/age sets, interest groups and voluntary associations, male and female roles, and taboos and mores. It is probably true that in twenty years there will be little of the European immigrant population left. It is also true that mass society will mitigate against many of the cultural inheritances of the previous generations, but there will always be the need for an objective analysis of the cultural elements in health care delivery. The problems may change, but the issue will always remain.

This paper has had to restrict its scope to a few elementary concepts. More direct observation of the hospital and other health care settings needs to be done. Delivery systems, though, are not the only aspect of health care that should be examined. Health services education could also benefit. It also is hoped that this paper will encourage further research in the general area of the ethnography of education. Additional ideas will be obvious to the anthropologist, the health specialist, and the educator. We solicit your comments and suggestions.

Jerry B. Clavner, Ph.D.
Veronica R. Sumodi, R.N.
Cuyahoga Community College
4250 Richmond Road
Warrensville, Ohio 44122

# APPENDIX

Area of study - Authority/Power

Concept - role behavior/role expectations

Definition: There exists a controversy, not unlike most controversies that cannot probably be resolved as to whether one is one's own man or woman or whether we are basically molded by those around us. The question is not simply for the academically curious, but is important with regard to our understanding of mobs, propaganda, advertising and authority. We are constantly being bombarded by family, friends, and the mass media, not only with information from which we could pick and choose but with persuasion that is aimed at giving us a distorted view of the world and subsequently ourselves. How we react is not necessarily a function of our intelligence or even a sense of our own good.

Readings: Stanley Milgram. Authority
Erving Goffman. Presentation of Self in Everyday Life.
Hans C. Anderson. The Ugly Duckling.

Activity Objectives: The student will be able to discuss the process of socialization as it relates to daily behavior.
The student will be able to describe habitual behavior and disruption of it and consequences.

Activity Instructions:

1. By now you've been in classes for a few weeks. Carefully observe the pattern of seating of those around you (but not in your nursing classes). Generally, most students sit in the same or almost the same seats each time even when not assigned to them. Chart their positions and their interactions with each other and the teacher.
2. Locate the student(s) who appear to wait for specific others to sit down so they can sit next to them or the student who always sits by the door.
3. Locate the students who sit in the front and the back. Chart the seating arrangements.
4. Take a person's seat and observe their behavior. Be oblivious of them, initially, but then smile and encourage them to sit next to you. Note: some people don't react at all, but others go bananas.

Write-up or Discussion Topics:

1. How much of our behavior is habit? Explain habit in terms of socialization.
2. Can deviant behavior mean that someone was raised differently? Explain.
3. What would happen if you took the teacher's place in class? Explain why this would happen.
4. What would happen if you changed seats at the family dinner table? Why?
5. What are the applications for work in a hospital setting?

Area of Study - Culture and Change

Concept - Acculturation/Assimilation

Definition: The concept of the United States as a melting pot is more wishful thinking than reality. While the diversity of the population remains one of its greatest strengths, differences in value systems that persist stand as potential barriers to effective communication. Individuals, even whole segments of population, may assimilate, that is, they may take on the outward appearance of the indigenous population. They may even assume the goals of their adopted land but they do not necessarily internalize the dominant culture's way of achieving these goals. Their affective as well as cognitive styles of coping may be different than that which we might be tempted to assume.

Readings: Clyde Kluckholn. Mirror for Man.
Laura Bohannan. "Shakespeare in the Bush"

Activity Objectives:
The practitioner will develop an awareness of alternative personality complexes. The nurse will be able to probe for meanings of different signs given by the patient/client verbally and non-verbally.

Activity Instructions:
1. Go to a grocery store (avoid supermarkets) in four different neighborhoods (e.g. Italian, Hungarian, Slovak, Mexican, Cuban, Jewish).
2. Make a list of foodstuffs not found in a mass market, supermarket.
3. Observe and record the general behavior and appearance of the shoppers.

Write-up or Discussion Topics:
1. Explain different ways two basic foodstuffs are prepared (e.g. potatoes, rice, tomatoes, beans) by these groups. Describe the traditional reasons for these manners of preparation. Is ritual or "magic" involved?
2. What are the implications for patient education of differing usage of herbs and spices?
3. How do you assist a patient to modify a traditional diet?

## March to a Different Drummer

Area of Study - Culture/Personality

Concepts - Values, Norms and Beliefs

Definitions: Most of the discussion in this paper is behavioral in nature. While it is difficult to teach values, they remain an important element of the cultural frameworks within which we work. The values, norms and beliefs and perceptions of importance of the institutions are essential elements in the effective delivery of health services. The nurse must be aware of her values and at least the possibility of different values of people with whom she interacts, including those of the patient and his/her family. In every thing from genetic counseling to oncology and thanontology, the ability of a nurse to understand and be understood is determined by these values. For example, a patient that has a disease/illness that "can go either way" may view that disease/illness as some form of personal punishment for past compromise on traditional values, whether in behavior or thought only. The nurse must get to the root of this feeling in order to be effective.

Readings: J.D. Salinger. Catcher in the Rye.
Kurt Vonnegut, Jr. Slaughterhouse Five.

Activity Objectives:

1. The student will develop a personal definition of personality.
2. The student will be able to describe the cultural, social, interactional and personal aspects of personality.
3. The student will be able to apply the idea of relativeness of values to real life situations.

Activity Instructions:

1. Mark your personal priorities from the list on the next page, (1) for the most important and (19) for the least important.
2. Write down the priorities of someone you think you know very well (husband, wife, intended, etc.).
3. Duplicate the blank list and ask the person you selected for #2 to list their own priorities.
4. Ask them to list what they think are your priorities.
5. Compare the four lists.

Write-up or Discussion Topics:

1. Define values, norms and beliefs. How do they operate in reality? Give examples of how they affect behavior.
2. Are values absolute or relative? Explain, using your activity.
3. Write a care/teaching plan for a patient that believes that deaths come in threes and has just "lost" two of his/her friends.

A COMFORTABLE LIFE
(a prosperous life)

EQUALITY
(brotherhood, equal opportunity for all)

AN EXCITING LIFE
(a stimulating, active life)

FAMILY SECURITY
(taking care of loved ones)

FREEDOM
(independence, free choice)

GOOD HEALTH
( physical, mental)

HAPPINESS
(contentedness)

INNER HARMONY
(freedom from inner conflict)

MATURE LOVE
(sexual and spiritual intimacy)

NATIONAL SECURITY
(protection from attack)

PLEASURE
(an enjoyable, leisurely life)

SALVATION
(saved, eternal life)

SELF-RESPECT
(self-esteem)

A SENSE OF ACCOMPLISHMENT
(lasting contribution)

SOCIAL RECOGNITION
(respect, admiration)

TRUE FRIENDSHIP
(close companionship)

WISDOM
(a matur understanding of life)

A WORLD AT PEACE
(free of war and conflict)

A WORLD OF BEAUTY
(beauty of nature and the arts)

Area of Study - Culture and Change

Concept - Age grade/Age Set

Definition: We continue to talk about a communications gap between people of different ages. In many respects this is a reality, caused by some real changes our society has undergone. Each and every generation sees the changes that it experiences as revolutionary. In many respects they are correct. Because we gave much of socialization (learning how to live in specific groups) and enculturation (learning how to live in general) over to groups other than the family and religion to handle, each new age group to come along learns not only different things but learns to think and feel differently.

Activity Objectives:

Teaching and ministering to different age groups requires not just information about biological changes and sensitivity to alledged psychological changes that people undergo as they age, we also need the skills to communicate and interact effectively.

Activity Instructions:

1. Ask 5 people in each of the following age groups - 18-22, 23-30, 30-45, 45-60, 60+, - to define these terms.

Internist
Psychosomatic
Dropsie
Convalescent
Rehabilitation
Nursing Home
Extended Care Facility
Crisis

2. Are there any significant differences between age groups?
3. Are there any terms that one age group or another could not define?
4. Compare the definitions in an abridged dictionary and the glossary of Tabers Medical Dictionary. Are there significant differences?

Write-up or Discussion Topics:

1. In interacting with patients of different ages what assumptions about different age groups should we and should we not make?
2. How would you overcome a "Communications gap" of a "Generation gap"? Would a nurse of a different age set understand patients differently?

## A Rose by any other Name May be an Allergy

**Area of Study - Culture, Language**

**Concepts - Signs/Symbols**

Definitions: It is interesting how we relate to certain objective phenomena - sometimes very predictably and sometimes not so predictably. In the social sciences signs or signals and symbols are two terms that can be used to help explain this behavior. The term sign has two overlapping meanings. Directly related to the study of individual behavior, as in psychology, sign stands for a genetically determined response to a given stimulus as in the pain felt when burnt or the eye blink when startled. Sign also refers to that which directly indicates something; a motion, gesture, or mark that appears to have virtual universal meaning.
Symbols, on the other hand, are genetically independent, that is, their meaning has to be agreed upon by a particular social group. Symbols stand for something else by association. The item, idea, or concept is not bound temporally or spatially. A red octagon and a skull and cross bones are two symbols. Confusion arises in that we combine signs and symbols. The red octagon usually says STOP and is at a corner. The skull and cross bones usually is accompanied by other indications of poison (or pirates). We even say stop sign. Yet in an international system of traffic signs, stop is indicated differently.
The dominant form of symbols of any culture is language, but not simply the denotative meaning of the words, but that which goes beyond. Words like cool, hot, square, even black and white conjure up images that are different for different aggregations and collectives of persons. The study of symbolizing has even crossed over into what once was thought to be beyond individual and social control, that is genetically determined responses; signs, in the area of body language and gestures, called **kinesics.**

Readings: **Mario Pei.** The Nature of Language.
Arnold Birenbaum and Edward Sagarin, "The Deviant Actor Maintains His Right To Be Present: The Case of the Nondrinker."

Activity Objectives:

1. The student will be able to distinguish between signs and symbols.
2. The student will be able to relate this concept to those of social and symbolic interaction after discussion of the latter.
3. The student will be able to describe differences of meanings of symbols and some of the reasons for these differences.

Activity Instructions:

1. Write down the first associations that come into your mind as you vocalize the words:

One
Two
Three



Over

2. Ask ten people (not in your class) to do the same. Make sure you get some data on these people, such as: age, sex, religion, race.

3. Compare your answers with your classmates.

Write-up or Discussion Topics:

1. Are numbers signs or symbols or both? Support your answer.

2. Are there any characteristics of the respondents that will allow you to categorize their responses? Why is this so?

3. If you asked persons from different countries or vocalized the numbers in different languages, like French or Spanish, would the answers be different? Why?

Area of Study - Traditions

Concept - Relationship/Affinity

Definitions: Relationship is a fuzzy term. Based on U.S. majority culture, we reckon our reality (to whom we are affiliated, related) and our descent (from whom we inherit biologically and materially) from both the maternal and paternal sides. Our kindred system, while not unique, may in part be based on our residence patterns-urban/neolocal (taking a new home in the city after our marriage.
Affinity has two meanings: to whom we are attracted and appear similar and those who are brought into contact/joined by a marriage as in the case of two sets of in-laws. The latter definition from anthropology may explain some of the problems health practitioners have with "families" of patients/clients. It is to the other half of the definition of affinity we must look for our solution.

Activity Objectives:

1. The student will learn some of the clues and cues for differentiating between "next of kin" and people with whom a patient wishes to interact.
2. The student will understand that different cultural groups have different rules and practices with regard to familial responsibilities.

Activity Instructions:

1. Select five students who are not in this class and ask them the following questions:
   a. If you were stuck on the road, who would you call for help?
   b. Whom would you call to borrow clothes for a party?
   c. If you had to be hospitalized out of town:
      1. Who should be notified?
      2. Who would be the most help to the doctor? with information about you?
      3. Who would you want by your bedside?

Remember to say thank you.

Write-up or Discussion Topics:

1. Who did your respondent name: friends, really closely related relatives, more distant relatives, or others?
2. Could age, sex or ethnic background explain respondents answers? Why?
3. Describe a possible problem in this area in a hospital setting and how it should be handled.

To the Instructor:

Our students need to become more aware of differences that exist among various ethnic groups as to who will actually be the most help in our work with a patient/client.

Students should not be told to abridge rules, but a need for flexibility should be encouraged. We all know that relatives don't always get along with each other and special attention should be paid to patients prior to and after visits from different persons.

Homecare and after care professionals also must be aware that "even though the wife of the patient has a sister who is an LPN", the patient may have strong ethnic prohibitions against being touched by his sister-in-law.

Area of Study: Gemeinschaft/Gesellschaft

Concept - Anonymity/Connectedness

Definition: One of the problems of the "melting pot" society is the possibility of the loss of identity. In a health care setting, this possibility becomes a probability with the need for efficiency of operation. Patient information and history taking is often reduced to that which is directly related to the problem at hand. The patient/client often does not have the opportunity to describe peripheral matters that are important for the delivery of holistic care.
Involvement with the community is essential. On-going liasons with specific as well as "umbrella" social agencies may be required. Sometimes the expertise needed is not available in the health care setting and practitioners must have access to outside resources.

Activity Objectives:

1. The student will learn about the availability of different types of services outside of the immediate setting.
2. The student will learn how to reduce the anonymity of patients/clients.

Activity Instructions:

1. Using the yellow pages:
   a. locate an ethnic association.
   b. locate a private social agency.
   c. locate a community health agency.
   d. locate a community mental health facility.
   e. locate a community "umbrella" or major referral agency.
2. Interview each of the above:
   a. for their function and role in the community.
   b. determine their hours of operation.
   c. determine their fee structure. Do they accept third party payment?

Write-up or Discussion Topics:

1. Under what circumstances would you use/need each of these agencies?
2. In a hospital setting which would you contact first?
3. Describe how to "follow up" after a referral.

SELECTED RESOURCES

While no materials were quoted or paraphrased directly in the paper, the reader should be aware of materials used. This list is submitted, not because it represents the best sources in the fields, but because these materials are typical. Sources for the suggested readings in the exercises are available from us if you will write us.


Abraham, Abraham S. Medical Halachah for Everyone. Jerusalem: Feldheim Press, 1980

Branch, Marie Foster. Providing Safe Nursing Care for Ethnic People of Color. New York: Appleton-Century-Croft, 1979.

Brownlee, Ann Templeton. Community, Culture and Care. St. Louis: C.V. Mosby, 1978.

Bower Fay L. and E. M. Olivia Bevis. Fundamentals of Nursing Practice. St. Louis: C.V. Mosby, 1979.

Burnside, Irene M. Psychosocial Nursing Care of the Aged. 2nd ed. New York: McGraw-Hill, 1980.

Davis, John W., Barry Hoffmaster and Sarah Shorten, eds. Contemporary Issues in Biomedical Ethics. Clifton, New Jersey: Humana Press, 1978.

Dolan, Josephine A. History of Nursing. 12th ed. Philadelphia: W.B. Saunders, 1968.

Downs, James. Cultures in Crisis. 2nd ed. London: Collier Macmillan, 1975.

Ellis, Janice and Celia Hartley. Nursing in Today's World. Philadelphia: J.B. Lippincott, 1980.

Haviland, William. Cultural Anthropology. 3rd ed. New York: Holt, Rinehart, and Winston, 1981.

Herskovitz, Melville. Cultural Relativism. New York: Vintage Books, 1963.

Hockett, C. F. Man's Place in Nature. New York: McGraw-Hill, 1973.

Jakobovitz, Immanuel. Jewish Medical Ethics (in Hebrew). Jerusalem: Mossad Harav Kook, 1976.

Leininger, Madeleine. Nursing and Anthropology: Two Worlds to Blend. New York: John Wiley, 1970.

Lennon, Sr. Mary I. Sociology and Social Problems in Nursing. St. Louis: C.V. Mosby, 1959.

Liederman, D., "Black and White Nurses' Inferences of Suffering," Nursing Times, April 27, 1978. pp. 108-110.

Luckman, Joan and Karen C. Sorenson, Medical-Surgical Nursing. 2nd ed. Philadelphia: W.B. Saunders, 1980.

Luckraft, Dorothy, ed. Black Awareness. New York: American Journal of Nursing Press, 1976.

McCurdy, David W. and James P. Spradley, eds. Issues in Cultural Anthropology. Boston: Little, Brown and Co., 1979.

Miner, Horace, "Body Ritual among the Nacerima," American Anthropologist, 58(1956), 503-507. (reprinted everywhere)

Moore, Lorna G., et. al. The Biocultural Basis of Health. St. Louis: C.V. Mosby, 1980.

Mosby's Comprehensive Review of Nursing. 9th ed. St. Louis: C.V. Mosby, 1977.

Murray, Ruth and Judith Zenter. Nursing Concepts for Health Promotion. Englewood Cliffs, New Jersey: Prentice Hall, 1975.

Price, Sylvia and Lorraine Wilson. Pathophysiology, Clinical Concepts of Disease Processes. 2nd ed. New York: McGraw-Hill, 1982.

Roach, Lora, "Color Changes in Dark Skin," Nursing 77, January, 1977. pp. 48-51.

Sorenson, Karen and Joan Luckman. Basic Nursing. Philadelphia: W.B. Saunders, 1979.

Spradley, James P. and David W. McCurdy, eds. Conformity and Conflict. Boston: Little, Brown and Co., 1977.

Sundeen, Sandra J., et. al. Nurse/Client Interaction. St. Louis: C.V. Mosby, 1981.

Whitney, Eleanor N. and Eva May N. Hamilton. Understanding Nutrition. 2nd ed. St. Paul: West Publishing, 1981.

Wu, Ruth. Behavior and Illness. Englewood Cliffs, New Jersey: Prentice-Hall, 1973.

Zborowski, Mark, "Cultural Components in Responses to Pain," Journal of Social Issues, 8(1953), 16-31.

Znaniecki, Florian. Cultural Sciences. New Brunswick, New Jersey: Transaction Books, 1980.

UNIVERSITY OF CALIFORNIA
ERIC® CLEARINGHOUSE FOR
JUNIOR COLLEGES
96 POWELL LIBRARY BUILDING
LOS ANGELES, CALIFORNIA 90024
EE 36

SEP 24 1982